Summary of Benefits

Washington County Public Schools

SERVICES	EPO	Maryland Point of Services (MPOS)		Preferred Provider Organization (PPO)	
	In-Network You Pay	In-Network You Pay	Out-of-Network You Pay	In-Network You Pay	Out-of-Network You Pay
ANNUAL DEDUCTIBLE					
Individual	$100	$100	$200	$100	$200
Individual & Child	$200	$200	$400	$200	$400
Individual & Adult	$200	$200	$400	$200	$400
Family	$200	$200	$400	$200	$400
ANNUAL OUT-OF-POCKET LIMIT					
Individual	None	$1,000		$1,000	
Individual & Child	None	$2,000		$2,000	
Individual & Adult	None	$2,000		$2,000	
Family	None	$2,000		$2,000	
LIFETIME MAXIMUM	None	None		None	
PREVENTIVE SERVICES					
Well-Child Care 0-17 years	No charge*	No charge*	No Benefit	No charge*	No Benefit
Adult Physical Examination (1 per benefit period)	No charge*	No charge*	No Benefit	No charge*	No Benefit
Routine GYN Visits (1 per benefit period)	No charge*	No charge*	No Benefit	No charge*	No Benefit
Mammograms	No charge*	No charge*	No charge*	No charge*	30% of Allowed Benefit, after deductible
Cancer Screening (Pap Test, Prostate and Colorectal)	No charge*	No charge*	No charge*	No charge*	30% of Allowed Benefit, after deductible
OFFICE VISITS, LABS AND TESTING					
Office Visits for Illness	$20 per visit	$20 per visit	Deductible, then 30% of Allowed Benefit	$20 per visit	30% of Allowed Benefit, after deductible
Diagnostic Services	No charge* after deductible	No charge* after deductible	No charge* after deductible	No charge* after deductible	30% of Allowed Benefit, after deductible
X-ray and Lab Tests	No charge* after deductible	No charge* after deductible	No charge* after deductible	No charge* after deductible	30% of Allowed Benefit, after deductible
Allergy Testing	No charge* after deductible	No charge* after deductible	Deductible, then 30% of Allowed Benefit	No charge* after deductible	30% of Allowed Benefit, after deductible
Allergy Shots	No charge* after deductible	No charge* after deductible	Deductible, then 30% of Allowed Benefit	No charge* after deductible	30% of Allowed Benefit, after deductible
Outpatient Physical, Speech and Occupational Therapy in office (limited to 60 visits/ benefit period combined)	$20 per visit	$20 per visit	Deductible, then 30% of Allowed Benefit	$20 per visit	30% of Allowed Benefit, after deductible
Outpatient Chiropractic	$20 per visit	$20 per visit	Deductible, then 30% of Allowed Benefit	$20 per visit	30% of Allowed Benefit, after deductible
EMERGENCY CARE AND URGENT CARE					
Physician's Office	$20 per visit	$20 per visit	$20 per visit	$20 per visit	$20 per visit
Urgent Care Center	$20 per visit	$20 per visit	$20 per visit	$20 per visit	$20 per visit
Hospital Emergency Room	$20 Physician; $50 Facility	$20 Physician; $50 Facility	$20 Physician; $50 Facility	$20 Physician; $50 Facility	$20 Physician; $50 Facility
Ambulance (if medically necessary)	No charge*	No charge*	No charge*	No charge*	No charge*
HOSPITALIZATION					
Inpatient Facility Services	$100 per admission copay	$100 per admission copay	Deductible, then 30% of Allowed Benefit	$100 per admission copay	30% of Allowed Benefit, after deductible
Outpatient Facility Services	$25 per visit	$25 per visit	Deductible, then 30% of Allowed Benefit	$30 per visit	30% of Allowed Benefit, after deductible
Inpatient Physician Services	No charge* after deductible	No charge* after deductible	Deductible, then 30% of Allowed Benefit	No charge* after deductible	30% of Allowed Benefit, after deductible
Outpatient Physician Services	$20 per visit	$20 per visit	Deductible, then 30% of Allowed Benefit	$30 per visit	30% of Allowed Benefit, after deductible

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HOSPITAL ALTERNATIVES					
Home Health Care (90 days unlimited visits per benefit period/40 visits home health aid per benefit period)	No charge* after deductible	No charge* after deductible	Deductible, then 30% of Allowed Benefit	No charge* after deductible	30% of Allowed Benefit, after deductible
Hospice (210 day lifetime max)	No charge* after deductible	No charge* after deductible	No charge* after deductible	No charge* after deductible	No charge* after deductible
Skilled Nursing Facility (60 days per benefit period)	No charge* after deductible	No charge* after deductible	Deductible, then 30% of Allowed Benefit	No charge* after deductible	30% of Allowed Benefit, after deductible
MATERNITY					
Prenatal and Postnatal Office Visits	No charge* after deductible	No charge* after deductible	Deductible, then 30% of Allowed Benefit	No charge* after deductible	30% of Allowed Benefit, after deductible
Delivery and Facility Services	$100 per admission copay	$100 per admission copay	Deductible, then 30% of Allowed Benefit	$100 per admission copay	30% of Allowed Benefit, after deductible
Nursery Care of Newborn	No charge* after deductible	No charge* after deductible	Deductible, then 30% of Allowed Benefit	No charge* after deductible	30% of Allowed Benefit, after deductible
Artificial Insemination and In Vitro Fertilization Procedures (limited to 2 combined attempts per lifetime)	Benefits available to same extent as benefits provided for other illnesses	Benefits available to same extent as benefits provided for other illnesses	Deductible, then 30% of Allowed Benefit	Benefits available to same extent as benefits provided for other illnesses	30% of Allowed Benefit, after deductible
MENTAL HEALTH AND SUBSTANCE ABUSE					
Inpatient Facility Services	$100 per admission copay	$100 per admission copay	30% of Allowed Benefit	$100 per admission copay	30% of Allowed Benefit
Inpatient Physician Services	No charge*	No charge*	30% of Allowed Benefit	No charge*	30% of Allowed Benefit
Office Visits for Mental Health and Substance Abuse	$20 per visit	$20 per visit	Deductible, then 30% of Allowed Benefit	$20 per visit	30% of Allowed Benefit, after deductible
Partial Hospitalization	No charge*	$25 per visit	Deductible, then 30% of Allowed Benefit	$30 per visit	30% of Allowed Benefit, after deductible
Medication Management Visit	$20 per visit	$20 per visit	Deductible, then 30% of Allowed Benefit	$20 per visit	30% of Allowed Benefit, after deductible
MISCELLANEOUS					
Durable Medical Equipment	No charge* after deductible	No charge* after deductible	No charge* after deductible	No charge* after deductible	30% of Allowed Benefit, after deductible
Acupuncture	$20 per visit	$20 per visit	Deductible, then 30% of Allowed Benefit	$20 per visit	30% of Allowed Benefit, after deductible
Transplants	Covered as stated in the Evidence of Coverage	Covered as stated in the Evidence of Coverage	Covered as stated in the Evidence of Coverage	Covered as stated in the Evidence of Coverage	Covered as stated in the Evidence of Coverage

**No copayments or coinsurance. Members are liable for the difference between CareFirst's allowed benefit and the providers charge for services rendered by a non-participating provider.*